STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155331	(X2) MULTIPLE CONSTRUCTION  A. BUILDING  B. WING  STREET ADDRESS, CITY, STATE, ZIP CO		(X3) DATE SURVEY COMPLETED 07/27/2011	
	PROVIDER OR SUPPLIEI		3405 N	CAMPBELL RD RAISO, IN46385		
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	J	(X5)
PREFIX	(EACH DEFICIEN	NCY MUST BE PERCEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD B	E	COMPLETION
TAG	REGULATORY OR	R LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCY)	WIL	DATE
l	This visit was for Complaint # INC Complaint # INC Federal/State de allegations are consumptions Survey dates: Ju Facility number: Provider number: AIM number:	or the Investigation of 00093820.  00093820-Substantiated, ficiencies related to the ited at F241 and F246.  lly 25, 26, and 27, 2011  1000224  155331 100267700  oni Krakowski, RN		CROSS-REFERENCED TO THE APPROPED DEFICIENCY)	RIATE	
	Medicare: 25	PC.				
	Medicaid: 59					
	Other: 13					
	Total: 97					
	Sample: 5 Supplemental sa These state findi accordance with	ings are cited in				
LABORATOR	Y DIRECTOR'S OR PRO	VIDER/SUPPLIER REPRESENTATIVE'S SIC	GNATURE	TITLE		(X6) DATE

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

(X6) DATE

Any defiencystatement ending with an asterisk (\*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

RCXC11

Facility ID:

000224

		X1) PROVIDER/SUPPLIER/CLIA	i i			(X3) DATE SURVEY COMPLETED	
AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		155331	A. BUII	LDING	00	07/27/2	
100001			B. WIN		DDDDGG GYRY GRUND GYD GODD	0112112	011
NAME OF P	ROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE  CAMPBELL RD		
LIFE CAF	RE CENTER OF VA	LPARAISO		1	RAISO, IN46385		
(X4) ID		TATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	ΓE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)	+	TAG	DEFICIENCE		DATE
		ompleted 8/1/11 by					
	Jennie Bartelt, R	N.					
F0241 SS=E	The facility must p a manner and in a maintains or enhand and respect in full individuality.  Based on interviet facility failed to presponding to resubstance. This consists and the second of the facility failed to presponding to resubstance. This consists and the second of the facility failed to presponding to resubstance. This consists are substance. The substance is a substance of the facility of the facility are substance. The substance is a substance of the facility of the facility are substance. The substance is a substance of the facility of the fac	romote care for residents in n environment that nees each resident's dignity recognition of his or her ew and record review, the provide dignified care by idents' request for deficient practice affected #B, #C, #F) reviewed for sample of 5 and 3 of 4, #J) in the supplemental ext., and #J were to oriented, and LPN #3 during initial to y on 7/25/11 at 9:15.  The interview on example of reach and the company of	FO	241	1. The complaint survey does identify specific residents affected. Please see respons #2.2. As any resident has the potential to be affected, the Director of Nursing requested permission from the Resident Council President to hold a Resident Council meeting on Thursday, August 11, 2011 a 10:00 am. Residents were informed of the meeting requiped by Activity staff and encourage to attend. Seventeen resident attended and interacted with Director of Nursing who spok about call light issues and the action plan being developed the facility to address concertidentified in the survey. All residents present were asked contribute their thoughts about the Resident Council minuted and educational training mate discussed are attached. Seducation is being provided each facility department head and/or the Staff Development Coordinator.	se to ed to to the second to to to test copy ites erials by different to the second to	08/19/2011
	who no longer liv	,			and/or the Staff Developmen	t	

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE SURVEY	
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:		LDING	00	COMPLETED
155331		155331	B. WIN	G		07/27/2011
NAME OF F	PROVIDER OR SUPPLIER		•	STREET A	ADDRESS, CITY, STATE, ZIP CODE	•
				1	CAMPBELL RD	
LIFE CAF	RE CENTER OF VA	LPARAISO		VALPAF	RAISO, IN46385	
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES			ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	*	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)	DATE
		sing the call light, but			specific to ensuring the placement of call lights in real	a ah in
	"Staff would com	ne in, turn the (call) light			l l	
	off and say they	would be back, but not			resident rooms and respond call lights with guidelines for	ing to
	come back in."				appropriate action to take if	
					unable to resolve a resident	
	Review of Reside	ent #C's clinical record			concern when answering the	l l
	on 7/25/11 at 2:1	5 P.M., indicated			light. The facility manageme team will be re-educated on	
	diagnoses of, but				participation in the Guardian	<b>I</b>
		ait and muscle weakness.			Angel program by the	
					Administrator or designee by	
	2. During an inte	rview with Resident #J			8/15/2011. Implementation of	of that
	_	05 A.M., she indicated			program focuses upon each	4
		ion when she activated			manager maintaining contact a specific group of residents	• • • • • • • • • • • • • • • • • • •
	her call light for				aid in eliciting and responding	
	_	e CNA (certified nursing			concerns regarding care with	- 1
		ded and told her she had			the facility. Initial contact with	
		urned off her light and			residents/responsible parties	
	·	ed if she put her call light			be attempted by no later tha 8/19/2011 and will continue	
	_	t #J stated, "I wheeled			minimum of once per month	• • • • • • • • • • • • • • • • • • •
	•	d found someone else to			six months. Concerns identif	
		a found someone eise to			will be forwarded to the	
	toilet me."				Administrator or designee fo	r
	2 D :1 ///:				attention and trending data accumulated. Posters focusi	na
		dicated in an interview on			attention on the proper	'' <sup>9</sup>
		A.M., "I'm supposed to			placement/response to call I	• 1
	_	ssible for myself so			will be conspicuously placed	
	- '	all) light on, I think they			staff break areas by 8/19/20	11.4.
	· ·	ise they want me to do it.			Administrative staff will be assigned to walking observa	tion
	They tell me, 'We	e know you're moving			rounds in all resident rooms	l l
		s on.' They have come in,			times per week for six month	<b>I</b>
	turned the light o	ff and not returned			starting on 8/17/2011. Each	_
	because they wer	e busy. I can't recall who			manager will be responsible	
	it was, but there l	has been more than one."			designated group of residen identified by room number.	
					staff members will adapt the	
	4. During an inte	rview with Resident #G			rounds to include observatio	l l
	<u>_</u>				<u> </u>	

	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155331	(X2) MULTIPL A. BUILDING B. WING	E CONSTRUCTION  00	(X3) DATE COMP - 07/27/2	LETED
NAME OF PROVIDER OR SUPPLIER  LIFE CARE CENTER OF VALPARAISO			STRE 340	EET ADDRESS, CITY, STATE, ZIP CO 5 N CAMPBELL RD PARAISO, IN46385	DE	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	CROSS-REFERENCED TO THE AP	OULD BE	(X5) COMPLETION DATE
	on 7/27/11 at 9:24 doesn't do any ge "You squeeze yo comes." She ind chair to get herse no one responds problem when the chair out of reach to make her way clinging to object her room until slethought maybe I had a problem who this morning the complaining the street was diagnost anxiety state, ost stenosis.  Resident #B's far an interview on that there have be light response has know they get be in the doorway as by and I call the room." She furth waited as long as Saturday, my comother and foun	Is A.M., she indicated it bood to use your call light. Four call light and no one licated she uses her wheel left to the bathroom when to the call light. "I have a ney (staff) push my wheel h." She indicated she had to her wheel chair by sets along the perimeter of the was able to reach it. "I was the only one who with the call light, but just ladies at my table were by had the same problem."  clinical record was 6/11 at 10:15 A.M. and sees of, but not limited to, the coarthrosis, and spinal spinal while, I stand and wait for staff to come me into my mother's the indicated she has seed a problem. "I have a while, I stand and wait for staff to come me into my mother's the indicated she has seed a seed a problem. "On the usin was visiting my down the recall light on at 6:00		call light placement ar response interviews. I the ongoing Call Light be amended as of 8/1 include questions regaresident satisfaction wresponse. Copy attact of these audits will be to the Administrator or for follow-up and the Administrator or design report these findings a monthly Performance Improvement Committ meetings where action be developed for any trends.	n addition, Audits will 5/2011 to arding with call light ned. Results forwarded designee nee will at the	

AND PLAN OF CORRECTION IDE		IDENTIFICATION NUMBER:		ULTIPLE CO	NSTRUCTION	(X3) DATE S	
				LDING	00	07/27/2	
			B. WIN		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF PROVIDER OR SUPPLIER				1	CAMPBELL RD		
	RE CENTER OF VA			VALPAF	RAISO, IN46385		
(X4) ID		TATEMENT OF DEFICIENCIES		ID PROVIDER'S PLAN OF CORE			
PREFIX TAG	`	CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		COMPLETION DATE
		called my mother that		0			5.112
		me they didn't put her to					
	bed until 7:00 P.1	2 2					
	6. During intervi	ew with Resident # F on					
	7/27/11 at 2:55 P	.M., she indicated she					
		ne summoning staff. "It					
		ood to put your call light					
		er for staff to respond."					
	When queried wl	-					
	'forever,' she responded, 45 minutes to an						
	hour."						
	Review of Reside	ent #F's clinical record on					
		.M. indicated diagnoses					
		d to, rheumatoid arthritis,					
	anxiety state, and						
	-						
	During a joint int	terview with the					
		d the Director of Nursing					
		0 P.M. they indicated					
	_	tra CNA at night to assist					
		e. They also indicated all					
	•	d to call lights and					
		ied staff (housekeeping, ance) have responded to					
	-	it failed to relay a need to					
	_	qualified to care for the					
		oth indicated they,					
		ond to call lights.					
		<b>5</b>					
	This Federal tag	relates to complaint					
	IN00093820.						

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:  155331			(X2) MULTIPL  A. BUILDING  B. WING	E CONSTRUCTION  00	(X3) DATE COMP. 07/27/2	LETED	
NAME OF PROVIDER OR SUPPLIER  LIFE CARE CENTER OF VALPARAISO			STREET ADDRESS, CITY, STATE, ZIP CODE  3405 N CAMPBELL RD  VALPARAISO, IN46385				
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI: TAG	CROSS-REFERENCED TO THE APPR	D BE	(X5) COMPLETION DATE	
F0246 SS=D	services in the fact accommodations of preferences, exces of the individual or endangered.  Based on observer record review, the call lights were were deficient practices (#C, #E) review sample of 5 and the supplemental Findings include  Residents #E and alert, oriented, and #3 during initial 7/25/11 at 9:15 Ard 1. During a telep 7/25/11 at 2:20 Prindicated Reside light to summon staff. "It was alw further indicated who no longer lives."	: d #H were identified as nd interviewable by LPN tour of the facility on	F0246	1. The complaint survey identify specific resident affected. Please see res #2.2. As any resident ha potential to be affected, Director of Nursing requipermission from the Resident Council President to hole Resident Council meeting Thursday, August 11, 20 10:00 am. Residents we informed of the meeting by Activity staff and encoto attend. Seventeen residented and interacted Director of Nursing who about call light issues an action plan being development of the facility to address condentified in the survey. It is response to call light of the Resident Council and educational training discussed are attached. Education is being provive each facility department and/or the Staff Develop	ponse to so the the ested ident d a g on 11 at re request buraged idents with the spoke d the ped by neerns All asked to about so. A copy minutes materials 3. ded by head	08/19/2011	

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED 00 A. BUILDING 155331 07/27/2011 B. WING STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 3405 N CAMPBELL RD LIFE CARE CENTER OF VALPARAISO VALPARAISO, IN46385 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES (X5) PROVIDER'S PLAN OF CORRECTION PROVIDER'S PLAN OF CORRECTION
(EACH CORRECTIVE ACTION SHOULD BE
CROSS-REFERENCED TO THE APPROPRIATE
DEFICIENCY) PREFIX (EACH DEFICIENCY MUST BE PERCEDED BY FULL PREFIX COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DATE Coordinator by 8/17/2011 for Resident #C by using his/her call light, facility staff in each department but "Staff would come in, turn the (call) specific to ensuring the light off and say they would be back, but appropriate placement of call not come back in." lights in reach in resident rooms and responding to call lights, with guidelines for appropriate action Review of Resident #C's clinical record to take if unable to resolve a on 7/25/11 at 2:15 P.M., indicated resident concern when answering diagnoses of, but not limited to, the call light. The facility abnormality of gait and muscle weakness. management team will be re-educated on their participation in the Guardian Angel program by 2. Resident #E's clinical record was the Administrator or designee by reviewed on 7/27/11 at 11:50 A.M. and 8/15/2011. This policy is indicated diagnoses of, but not limited to, attached. Implementation of that program focuses upon each fractured left leg, muscle weakness, and manager maintaining contact with seizure disorder. a specific group of residents to aid in eliciting and responding to During observation of Resident #E on concerns regarding care within the facility. Initial contact with 7/27/11 at 1:00 P.M., she was observed residents/responsible parties will sitting in her wheel chair in her room. She be attempted by no later than was eating her lunch and was alone in the 8/19/2011 and will continue at a room. Her call light was attached to the minimum of once per month for six months. Concerns identified bed rail on the opposite side of the bed will be forwarded to the and was well out of her reach. When Administrator or designee for gueried as to what she would do if she attention and trending data needed to summon the nurse, she accumulated. Posters focusing responded, "I would hope." attention on the proper placement/response to call lights will be conspicuously placed in 3. Resident #H was observed sitting staff break areas by 8/19/2011.4. alone in her room eating her lunch. She Administrative staff will be was up in her wheel chair and had a assigned to walking observation rounds in all resident rooms three bedside table pushed up to the front of times per week for six months her. Her call light was clipped to the starting on 8/17/2011. Each privacy curtain on the opposite side of her manager will be responsible for a bed. When queried how she would designated group of residents

li *		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M	MULTIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
ANDILAN	OF CORRECTION	155331	- 1	ILDING	00	07/27/2	
		1.0000	B. WIN		ADDRESS, CITY, STATE, ZIP CODE	• • • • • • • • • • • • • • • • • • • •	
NAME OF PROVIDER OR SUPPLIER				1	CAMPBELL RD		
LIFE CA	RE CENTER OF VA	ALPARAISO		1	RAISO, IN46385		
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES			ID	PROVIDER'S PLAN OF CORRECTION	(X5)	
PREFIX	`	ICY MUST BE PERCEDED BY FULL	PREFIX		(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT	ΓE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	summon help if she needed to, she stated,				identified by room number. The staff members will adapt their		
	"I guess I would	have to yell."			rounds to include observation		
					call light placement and call l		
	During a joint in	terview with the			response interviews. In addit		
	Administrator ar	nd the Director of Nursing			the ongoing Call Light Audits		
	on 7/27/11 at 3:5	50 P.M. they indicated			be amended as of 8/15/2011	to	
	they added an ex	tra CNA at night to assist			include questions regarding resident satisfaction with call	light	
	1 -	e. They also indicated all			response. Copy attached. Re		
		d to call lights and			of these audits will be forwar		
	1	fied staff (housekeeping,			to the Administrator or design	nee	
		ance) have responded to			for follow-up and the		
	the call lights, but failed to relay a need to				Administrator or designee wi	II	
	1	e qualified to care for the			report these findings at the monthly Performance		
		•			Improvement Committee		
	1	oth indicated they,	meetings where action plans will				
themselves, respond to call lights.		ond to call lights.		be developed for any negative			
					trends. These audits will be o	done	
	_	relates to complaint			three times per week for six months. All concerns and au	<b>-1:1</b>	
	IN00093820. 3.1-3(v)(1)				data are to be forwarded to the		
					Administrator or designee for		
					follow-up and the Administra		
					designee will report these fin	dings	
					at the monthly Performance		
					Improvement Committee	will	
					meetings where action plans be developed for any negative		
					trends.This is my credible		
					allegation		